Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150
www.kbml.ky.gov

Institutional Practice Limited License Instructions

Upon completion of the online application for the Institutional Practice Limited License the following requirements will need to be completed:

FCVS Packet:
Federation Credentials Verification Service (FCVS) is a service of the Federation of State Medical Boards and is required by the Kentucky Board of Medical Licensure. The FCVS provides a permanent central depository for documents, which represent the core credentials of any physician. By using this service, the following core credentials are verified and kept in your lifetime portfolio for future credentialing by the FCVS:

- Identity
- Medical Education Verification
- Postgraduate Training Verification
- Exam Scores
- ECFMG and/or Fifth Pathway

To complete the FCVS application go to http://www.fsmb.org/fcvs.html. Choose **Physician** on the left of your screen. Then choose **Applications and Forms**. Please be sure to read information and follow the instructions provided for you on each screen you come to.

Important information for when you are completing your FCVS application:
You need to designate Kentucky as recipient of your FCVS Profile
You need to designate your Residency Coordinator as **Authorized to Speak To** on your FCVS packet
You need to indicates that the type of license you are applying for is **Institutional**
Make sure to submit all of the required documents to the FCVS at the address below:

Federation Credentials Verification Service
PO Box 970900
Dallas, TX 75397-0900
(888) 275-3287

The FCVS will provide all support of their credentialing process. Please do not contact the Kentucky Board of Medical Licensure regarding the FCVS application. The FCVS has a dedicated staff to ensure the processing of your application in professional and timely manner. The FCVS will provide an acknowledgment of receipt of your application in approximately **three days**, a subsequent notice of items needed to complete the credentials verification process in approximately **ten days**, and periodic reminders about any materials that remain outstanding every **three weeks** thereafter. In addition, each applicant will be given a unique packet number that will allow you to check the status of your application on-line. If you have previously completed the application process through FCVS, you will need to request a subsequent application packet. This process should take approximately 3-4 weeks and be virtually pain-free!

Upon completion of all information and a final review for accuracy, the FCVS will forward your "Physician Information Profile" containing certified photocopies of your credentials directly to the Kentucky Board of Medical Licensure.

7/9/10

Kentucky Board of Medical Licensure Training Application Process

Next, you will need to complete the application for the Kentucky Board of Medical Licensure and submit this application directly to the Board along with the $75.00 fee. You may submit your Board application at the same time that you submit your FCVS application. The Board will use this information, along with the FCVS Profile, to assess your qualifications for licensure.

Applications will be reviewed in the order they are received in our office. It takes approximately 60 – 90 days to complete the processing of an application, assuming you have submitted all necessary forms and all outside information/verifications have come in to the Board, including the FCVS Profile. If you have malpractice, disciplinary history, or we receive any negative or derogatory information during the processing of your application, **you will need to allow an additional 30 – 60 days to complete.** The Board does not accelerate processing of one applicant at the expense of another because of a premature commitment made on your behalf, nor will it forego any elements of its screening process. Please do not make firm commitments to start work on any certain date until you have your license in hand.

Once your application has been reviewed, you will receive an acknowledgement letter advising you of anything still needed to complete your file. You should allow at least 30 days for this process.

Applications must be printed legibly or they will be returned. Please complete all questions in its entirety. Do not leave any blanks or time not accounted for. Mark N/A in areas not applicable. Incomplete applications will remain in our office for one (1) year from the date your application is stamped received by KBML. After one year, your file will be purged and you will have to start the application process over in its entirety including the fee. Also note that the $75.00 licensure fee is non-refundable so be sure that you meet all requirements for the training license, which are listed on the following page before completing and returning the application to this office.

We ask your cooperation in limiting your calls to the office to check on the status of your application. Please allow at least 30 days to receive notification of receipt and status (this could be delayed during peak months).

For Information Regarding The Status of an Application on File:

- Files with last name beginning A – K
  Rachel Noyes, Licensure Coordinator
  Email: jrachel.noyes@ky.gov
  Phone: 502/429-7150, ext. 222

- Files with last name beginning L – Z
  Christina Ford, Licensure Coordinator
  Email: christina.ford@ky.gov
  Phone 502/429-7150, ext. 223

Kentucky Board of Medical Licensure

Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
Licensure Telephone: (502) 429-7150

TO: Applicant for Institutional Practice Limited License/Residency Training

FROM: C. William Schmidt, Executive Director

RE: Application for Institutional Practice Limited License/Residency License

Attached is an application for an Institutional Practice or a Residency Training Limited License to practice medicine in an approved residency-training program in Kentucky. Instructions for completing this form and all supporting documentation are included. Pleased be advised that completion of the application for licensure is solely your responsibility.

Applicants for an ***Institutional Practice Limited License*** must meet the following criteria:

1. Have successfully completed 1 year of accredited postgraduate training in the United States or Canada.
2. Passed FLEX component 1 with a 75% or above; or, completed the FLEX in 1 sitting with a 75% or above or passed the NBME, NBOME/COMLEX Parts 1 and 2; or, passed the USMLE Steps 1 and 2.
3. Must be accepted into the accredited training program. Form **IP** must be completed by your Kentucky program director.

Applicants for a ***Residency Training License*** must meet the following criteria:

1. Have successfully completed 1 year of accredited postgraduate training in the United States or Canada.
2. Passed the FLEX in one sitting with a 75% or above; or, passed the NBME, NBOME/COMLEX Parts 1, 2 and 3; or, passed the USMLE Steps 1, 2 and 3.
3. Must be accepted into the accredited training program. Form **R** must be completed by your Kentucky program director recommending that a resident training license be issued to you.

This license will be issued on an academic year, July 1 – June 30, and will limit your legal ability to practice medicine to the institution and/or setting(s) approved by the postgraduate training program.

Only completed applications will be considered by the Board. Incomplete applications will be returned to the applicant. The Board (KBML) meets quarterly to review applications for medical licensure. Your application along with the $75.00 non-refundable licensure fee, and all supporting documentation must be received by the designated deadlines in order to be reviewed at the next regularly scheduled Board meeting. Please see enclosed for the schedule of meeting dates and deadlines.

This application and all supporting documents may be printed from our web site and **mailed** to the Board at the address above. Should you have any questions regarding the above, please contact the Board at (502) 429-7150, between 8:00 a.m. and 4:30 p.m., ET, Monday through Friday. **Faxed Applications will not be accepted.**

Application Deadlines and Board Meeting Dates

In order for your application to be presented to the Board, your application ***must be completed in its entirety and must be on file in the Board office by the deadline*** dates listed below. The fact that you have mailed the application form and fee does not constitute a completed application. Your application is complete when the Board staff has reviewed all parts of the application, including the FCVS Profile. You should allow a minimum of six to eight weeks for attachments to reach this office and be incorporated into your file.

Deadline Dates For Regular Applicants	Board Meeting Dates
February 19, 2010	March 18, 2010
May 28, 2010	June 24, 2010
August 27, 2010	September 23, 2010
November 19, 2010	December 16, 2010

If you are notified by the KBML that your application will be presented to the Board as a **"Special Application"**, your deadline will be different from the above dates. Please refer to the dates below:

Deadline Dates For "Special Applicants"	Board Meeting Dates
February 5, 2010	March 18, 2010
May 14, 2010	June 24, 2010
August 13, 2010	September 23, 2010
November 5, 2010	December 16, 2010

Institutional Practice Limited License/Residency Application

Please type or print clearly. Applicant must answer all questions. Incomplete applications will be returned. Faxes will not be acceptable.

Completion of the Application Form:

- **Item 1** – Important – Use your full legal name. Do not use nicknames, etc. This is the name that will be printed on the license and reported to all outside entities inquiring about licensure. List the degree designation as conferred by your medical/osteopathic school.
- **Item 2 & 3** – Provide the address of your program. All correspondence is sent directly to the program. (i.e., UL, GME Office; UKMC HQ101, 800 Rose St.)
- **Item 7** – List the name of the program and department that you have been accepted.
- **Item 8** – Specify what PGY level you will be entering and your specialty/department.
- **Item 9** – List all colleges and medical/osteopathic schools attended in chronological order, even if a degree was not obtained.
- **Item 10** – List all training in the US and/or Canada in chronological order that is ACGME accredited. Use an additional sheet if necessary.
- **Item 11** – List all licenses you currently hold or ***have ever held***. Include all training, locum tenens, etc.
- **Item 13** – List all licensing examinations taken, including failures.

Requirements for Additional Documentation

Required fees include:

- **$75.00** Licensure Fee (This fee is non-refundable and must be submitted with your application)

Applicant's Checklist - Residency Training License

The following is a summary of items to help you complete your application process. Please refer to the application for complete instructions. This form is your checklist to keep for reference.

_____ FCVS Application submitted directly to FCVS with Fee

_____ Form 1 – License Verifications (Send to every Board where licenses have been held)

_____ Form 2 – Hospital/Clinic Affiliation Listing(Send directly to KBML)

_____ Form 2A – Hospital/Clinic Affiliation Verification(Send to each facility where you have practiced medicine in the last 5 years)

_____ Form 4 – Release and Waiver of Rights

_____ Recent Photograph – 2x2 passport attached to application where indicated

_____ Form 7 - HIV/AIDS Education Requirement (Copy of certificate once completed) (http://chfs.ky.gov/dph/epi/hivaids/professionaleducation.htm)

_____ Application with $75.00 Non-Refundable Fee Mailed to KBML on _____

Verification of Primary Source Documents

Faxes Will Not Be Accepted

- **Form 1** - **Verification of Licensure** - This form must be completed by each state/province in which you currently hold or have ever held any license to practice medicine/osteopathy (Include temporary and/or training licenses). This form must be sent directly to us from each state board and must contain the seal of the state board. Any fees required for the completion of this form are your responsibility.

- **Form 2** - **Hospital/Clinic Affiliations -** Complete this form and return along with your application. List all hospital/clinic affiliations held for the past five (5) years excluding training. Include all locum tenens assignments and moonlighting.

- **Form 2A** - **Hospital/Clinic Affiliation Form** - This form must be completed by all hospitals and/or clinics, locum tenens assignments, and moonlighting, within the past 5 years. The form should be completed by administration or chairpersons and mailed directly to KBML. (Do not include private practice or training)

- **Form 4** - **Release and Waiver of Rights Form** - Please read carefully. This form must be signed in front of a notary and returned along with your application.

- **Photograph** – Attach (do not staple) a recent **2x2 passport photograph** on application where indicated. Sign and date across the bottom. Photograph must be no more than six months old and must be an original photograph. (Copies and scanned photos are not accepted)

- **Form 7 - HIV/AIDS CME Requirement** - Effective July 1, 1991, all applicants for medical licensure must comply with the two (2) hour HIV/AIDS education requirement mandated by the Kentucky General Assembly. All applicants must submit a copy of a completed course certificate prior to the Board issuing a license. A list of approved courses may be obtained at the following web site:

  http://chfs.ky.gov/dph/epi/hivaids/professionaleducation.htm

- **IP Form or R Form** – This form must be completed by your Program Director from the program that you have been accepted to in Kentucky. The Board will not issue a license without this form from your Director indicating their recommendation for you to obtain either the IP or R training license.

Application for Institutional Practice Limited License or Residency Training License

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150

1. Name in Full: _____
   (First) (Middle) (Last) (Degree)

2. Address _____
   _____

3. City, State, Zipcode _____

4. Social Security Number: _____

5. Telephone: Home ( ) _____Work ( ) _____

6. Place of Birth (State): _____Date of Birth: _____

7. What residency program have you been accepted in to Kentucky?_____

8. Specify level (year) of training: _____ Specialty: _____

9. List name, location and dates of attendance of every college and medical school you have attended:

Name	Location	Dates (From – To)	Degree

10. List all internship and residency programs you have completed since medical school graduation.
    Please list in chronological order: (Question continues on next page)

    Internship: (List US and Canadian only)

    Hospital: _____

    City, State: _____

    Term: Started _____ Completed _____

Name: _____ **Social Security Number:** _____

Residency: (List US and Canadian only)

Hospital: _____

City, State: _____

Term: Started _____ Completed _____

Residency: (List US and Canadian only)

Hospital: _____

City, State: _____

Term: Started _____ Completed _____

11. List all states and Canadian provinces where you **currently hold or have ever held** any type of medical license:

State/Province	Type	License Number	Date of Issuance	Current Yes/No

12. Indicate your ECFMG number, if applicable: _____

13. Indicate which licensing examination(s) you have taken. Include **all attempts and failures.**

Type of Exam: (FLEX,NBME,USMLE,etc)	Location	Score	Date

Name: _____ Social Security Number: _____

[Category I]

Please answer all questions on this application. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification.
If you answer "Yes" to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer "yes" in such circumstance even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license.

1. Have you ever been dismissed from, resigned while under investigation or failed to complete an academic year, taken a leave of absence, or been placed on probation or reprimanded at a medical school or a postgraduate training program?
   ☐Yes ☐ No

2. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
   ☐Yes ☐ No

3. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
   ☐ Yes ☐No

4. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action by a State medical/osteopathic licensing board, or Federal, or International authority?
   ☐Yes ☐No

5. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
   ☐Yes ☐ No

6. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
   ☐Yes ☐ No

7. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
   ☐Yes ☐No

8. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
   ☐Yes ☐ No

Name: _____ **Social Security Number:** _____

9. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
   ☐Yes ☐No
10. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
   ☐Yes ☐No
11. Are any legal proceedings regarding licensure presently pending against you by any state, Federal or International licensure authority or any drug licensure/enforcement authority?
   ☐Yes ☐ No
12. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?
   ☐Yes ☐No
13. To your knowledge, are you the subject of an investigation for a criminal act?
   ☐Yes ☐No
14. In the past ten (10) years have you had to pay a judgment in a malpractice action or other civil action against your medical practice or are any malpractice or other civil actions against you or your medical practice presently pending in any court? (If yes, complete enclosed **Medical Malpractice Form**)
   ☐Yes ☐No

*****Affidavit of Applicant*****

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board or its agents to obtain form other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

_____

(Signature of Applicant) **(Date)**

Subscribed and sworn to before me by the above named applicant this _____day of _____
(month, year)

_____

(Signature of Notary)

My commission expires: _____ **Seal of Notary**

Attach current 2x2 passport photograph here. Sign and date across bottom. Photo must be a head and shoulder view and must be taken within six months of application.

Name: _____ ***Social Security Number:*** _____

[Category II]

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (l) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.
"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
4. Within the past 5 years, have you engaged in the excessive use of alcohol of illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
   ☐Yes ☐No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
   ☐Yes ☐ No

*****Affidavit of Applicant*****

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection wit this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

_____ _____
(Signature of Applicant) **(Date)**

Subscribed and sworn to before me by the above named applicant on this_____day of _____
(month, year)

_____
(Signature of Notary

My commission expires: _____ **Seal of Notary**

R Form

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150
www.kbml.ky.gov

(This form must be completed by a Kentucky Program Director)

I hereby confirm that _____ is in good standing in his/her
(Applicant's Name)

training program at _____.
(Residency Program and Department)

I recommend that the Board issue a residency-training license to the above named applicant so that he/she may practice medicine in that institution and/or a setting(s) approved by that residency-training program.

_____ _____
(Printed name of Program Director) **(Telephone Number)**

_____ _____
(Signature of Program Director) **(Date)**

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-7150
www.kbml.ky.gov

(This form must be completed by a Kentucky Program Director)

I hereby request _____ to be issued an
(Applicant's Name)

Institutional Practice Limited License to complete his/her residency-training program at

_____.
(Residency Program and Department)

_____ _____
(Printed name of Program Director) **(Telephone Number)**

_____ _____
(Signature of Program Director) **(Date)**

Kentucky Board of Medical Licensure

310 Whittington Parkway, Suite 1B
Louisville, KY 40222

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement. Your application is not complete until this form has been returned to the Board.

_____

Name of Physician *Office Telephone No.*

_____

Address *City* *State* *Zip*

***Malpractice Complaint**: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)*

Patient's Name: _____

Age: _____ *Sex:* _____

Date/Place of Occurrence: _____

Indicate you position in case, i.e., resident, primary physician, etc: _____

_____

Filed Against: *( ) Individual Doctor ( ) Group ( ) Hospital*

List names of other defendant-doctors and/or hospitals: _____

_____

Disposition: *( ) Pending ( ) Jury Verdict ( ) Settled*

If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Date: _____ *Total Amount Paid (if any):* _____

Amount attributable to you: _____

Send To This Board Copies Of The Complaint, Answer, Release, Settlement Documents, All Other Relevant Legal Documents.

On A Separate Sheet, Please Provide A Detailed Explanation Of Background And Medical Issues Involved In The Case.

Signature: _____ *Date:* _____

***Note:** A separate report must be completed for each malpractice suit. This form may be duplicated. Please return form(s) and other information to the Board at the above address.*

Form 1

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Verification of Licensure

To Applicant: In applying for a license to practice medicine/osteopathy in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires **each** state or Canadian province where you currently hold or have ever held a medical license complete this form. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name of Applicant: _____M.D./D.O. License No:_____
(Please print)

Address:_____

_____ _____M.D./D.O.
(Signature)

****

To Reference Source: Please complete this form, sign, seal and return ***directly*** to the Board (KBML) at the above stated address. Any fees for completion of this form should be collected from the physician. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

• • • Please Type or Print All Information • • •

State of:_____License No:_____

Issue Date:_____ Expiration Date:_____

Basis for Licensure:_____

Current Status:_____

Limitations: _____

Derogatory:_____

_____

Board Seal

Signed: _____

Title: _____

Form 2

Physicians Name _____M.D. / D.O.

List all hospitals, clinics, etc., other than training where you have practiced medicine within the last five (5) years and send Form 2A to each. *(This should also include moonlighting, administrative, and all locum tenens assignments.)*

Dates (From – To)	**Hospital/Clinic/Office Name**	**Complete Address**	**Indicate Locum Tenens, Moonlighting or Type of Privileges**

Form 2A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application (excluding training). My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name:_____M.D./D.O. _____
(Please print) (Signature)

Name and Address of Facility_____

****

To Reference Source: Please complete this form; sign and return ***directly*** to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.

1. Position and Department of the above applicant?_____
2. Affiliation Dates: From _____To _____
3. Were any limitations imposed on this physician? _____If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action. _____
   _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined?____ If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action.
   _____
   _____
5. Was the above physician terminated from employment? ____ If yes, please explain in detail.

   Derogatory Information, if any:_____

   Comments, if any:_____

Signature, Date, Title _____
Printed Name _____
Name of Facility _____
Affix Seal Here Address _____
(If no seal, so indicate) Date/Phone # _____

Form 4

Release and Waiver of Rights Form

I, _____, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All medical/osteopathic schools that I have attended.

2. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.

3. All medical/osteopathic societies, specialty boards, and other medical/osteopathic organizations with which I have been associated.

4. All other state or Canadian licensure boards, federal health agencies, and federal and state drug control agencies.

5. All licensed physicians, nurses or other health care professionals of any state or Canadian province.

6. All attorneys who have participated in civil or criminal actions in which I was named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me, which is relevant to the requirements for licensure. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for a license to practice medicine/osteopathy in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued licensure.

This release and waiver of rights has no expiration date and shall remain effective during my licensure in the Commonwealth of Kentucky.

_____

(Applicant's Signature) (Date)

_____

(Print Name)

Sworn to and Subscribed Before Me By the Above Named Applicant on this the ___day of _____, 20 _____.

Seal

_____

Notary Public

My Commission expires:_____

Form 7

Kentucky Board of Medical Licensure

HIV/AIDS Education Documentation Requirements

During the 1990 regular legislative session, the General Assembly passed House Bill 425, which mandated Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) education requirements for health professionals. Further, the General Assembly mandated that the Cabinet for Health Services (CHS) administers this program and that the Kentucky Board of Medical Licensure monitor compliance.

On or after September 24, 1991, all applicants for medical licensure must comply with the two (2) hour AIDS education requirement.

Prior to receiving a Kentucky medical license, each applicant for licensure must submit to the Kentucky Board of Medical Licensure one of the following:

- A copy of a certificate of completion of an approved course. The AIDS course (2 hours minimum) must be included on the official listing of approved courses maintained by the Cabinet for Health Services, and the CHS approval number must appear on the certificate. **Certificates without a CHS approval number will not be accepted.** Contact the Provider of your course if the approval number is not listed on your certificate.

- If an applicant has graduated from a medical/osteopathic school, whose AIDS education is approved by CHS, within five (5) years and has been in a residency program throughout the interim, the applicant shall be deemed to have met this requirement. Contact the AIDS Education Program at CHS to see if your medical school curriculum has been approved. (See below)

If you have any questions regarding applicable courses, approval of courses, or if you need to obtain a listing of approved courses, please contact:
http://chfs.ky.gov/dph/epi/hivaids/professionaleducation.htm

AIDS Education Program
Cabinet for Health Services
275 East Main Street
Frankfort, KY 40621
(502) 564-4990

Your Kentucky Medical License will not be issued until you have fulfilled this CME requirement and forwarded the certificate of completion to KBML.